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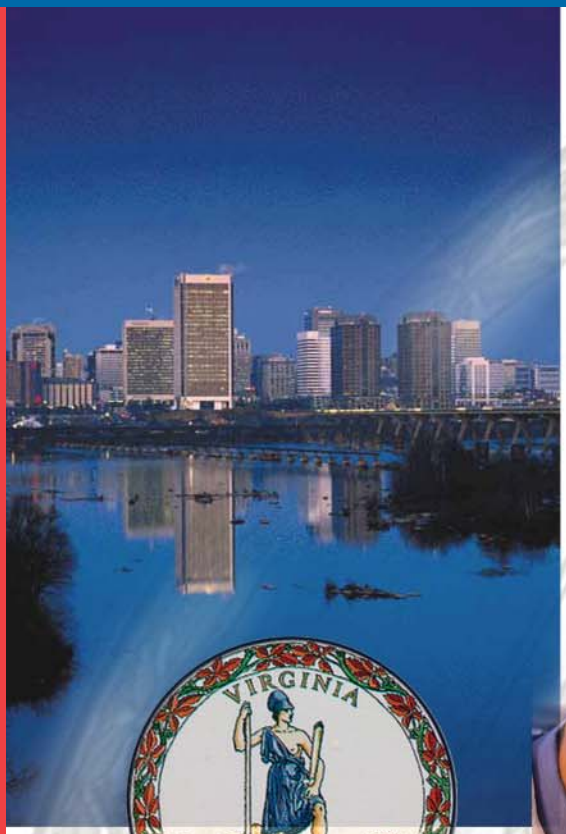

Commonwealth of Virginia Department of Medical Assistance Services

External Quality Review

Anthem BlueCross/BlueShield

Annual Report CY 2005

Improving Healthcare in the Communities We Serve.

Anthem BlueCross/BlueShield Annual Report

Introduction and Purpose

The Virginia Department of Medical Assistance Services (DMAS) is charged with the responsibility of evaluating the quality of care provided to recipients enrolled in contracted Medallion II managed care plans. The intent of the Medallion II program is to improve access to care, promote disease prevention, ensure quality care, and reduce Medicaid expenditures. To ensure that the care provided meets acceptable standards for quality, access, and timeliness, DMAS has contracted with the Delmarva Foundation for Medical Care, Inc. (Delmarva) to serve as the External Quality Review Organization (EQRO). This annual report will include the overall results of the Operational Systems Review as well as the findings related to quality, access and timeliness of care.

Following federal requirements for an annual assessment, as set for the in the Balanced Budget Act of 1997 (BBA) and federal EQRO regulations, Delmarva conducted a comprehensive review of MCO Name to assess the MCO's performance relative to the quality of care, timeliness of services, and accessibility of services.

For purposes of assessment, Delmarva has adopted the following definitions:

- **Quality,** stated in the federal regulations as it pertains to external quality review, is "the degree to which a Managed Care Organization (MCO) or Prepaid Inpatient Health Plan (PIHP) increases the likelihood of desired health outcomes of its recipients through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge" ("Final Rule: External Quality Review," 2003).

- **Access** (or accessibility), as defined by the National Committee for Quality Assurance (NCQA), is the "timeliness in which an organization's member can obtain available services. The organization must be able to ensure accessibility of routine and regular care and urgent and after-hours care" ("Standards and Guidelines," 2003).

- **Timeliness,** as it relates to utilization management decisions, is defined by NCQA as when "the organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation. The intent is that organizations make utilization decisions in a timely manner to minimize any disruption in the provision of health care" ("Standards and Guidelines," 2003). An additional definition

of timeliness given in the National Health Care Quality Report "refers to obtaining needed care and minimizing unnecessary delays in getting that care" ("Envisioning the National Health Care," 2001).

This annual report provides an evaluation of data sources reviewed by Delmarva as the EQRO to assess the progress that Medallion II managed care plans have made in fulfilling the foals of DMAS. This annual report is a mandated activity in the Medallion II contract and the BBA External Quality Review regulations.

Although Delmarva's task is to assess how well Anthem Blue Cross/Blue Shield (Anthem) performs in the areas of quality, access, and timeliness from Health Employer Data and Information Set (HEDIS®[1]) performance, performance improvement projects (PIPs), and operational systems review perspective, it is important to note the interdependence of quality, access, or timeliness also may be noted under either of the other two areas.

Quality, access and timeliness of care expectations for all persons enrolled in the Medallion II managed care program. Ascertaining whether health plans have met the intent of the BBA and state requirements is a major goal of this report.

Background on Plan

Anthem consists of three health plans that provide managed care services to Medallion II enrollees in various localities throughout the state of Virginia. These health plans include Anthem HealthKeepers, Inc.; Anthem Peninsula Health Care, Inc.; and Anthem Priority Health Care, Inc. Enrollment in all VA Anthem health plans was 95, 151 members as of December 2005. Localities covered by Anthem are the Tidewater, and Central Virginia, Halifax and Winchester regions. Anthem began providing services to Medallion II enrollees in January 1996 and is an NCQA-accredited health plan with an excellent accreditation status.

Data Sources

Delmarva used three major data sources to evaluate the Anthem's performance:

- HEDIS, which is a nationally recognized set of performance measures developed by NCQA. These measures are used by health care purchasers to assess the quality and timeliness of care and service delivery to members for managed care delivery systems.
- Summaries of plan-conducted Performance Improvement Projects.
- Operational Systems Review, consisting of a pre-site and on-site review.

[1] HEDIS ®is a registered trademark of the National Committee for Quality Assurance.

Methodology

Delmarva performed an external independent review of all data from the three sources above. The EQRO has assessed quality, access, and timeliness across the three data disciplines. After discussion of this integrated review, Delmarva will provide an assessment to DMAS regarding how well the health plan is providing quality care and services to its members.

The BBA requires that performance measures be validated in a manner consistent with the External Quality Review protocol *Validating Performance Measures*. Audits are to be conducted as prescribed by NCQA's *HEDIS 2005, Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures*[2] and is consistent with the validation method required by the EQRO protocols. Each Medallion II MCO uses NCQA protocols, including the Data Submission Tool (DST) to capture and compute its HEDIS results. The HEDIS data in this report have been taken directly from the Data Submission Tool (DST) completed by each MCO, but were not audited by Delmarva. This report contains data results of common HEDIS measures, each of which was calculated by all Medallion II managed care plans.

During the HEDIS 2006 reporting year, Medallion II MCOs collected data from calendar year 2005 related to the following clinical indicators as an assessment of quality, access, and timeliness:

- Childhood Immunization Status
- Adolescent Immunization Status
- Breast Cancer Screening
- Prenatal and Postpartum Care
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life
- Adolescent Well-Care Visit

PIPs also are used to assess the health plan's focus on quality, access, and timeliness of care and services. Although the PIPs address clinical issues, barrier analysis often leads to issues of access or timeliness as major contributing factors that affect the attainment of the clinical quality goals. During 2004, Anthem implemented two PIPs, aimed at addressing clinical issues pertinent to the health plan's population. Delmarva reviewed the health plan's PIPs, assessed compliance with DMAS contractual requirements, and validated the activity for interventions as well as evidence of improvement. The baseline year for PIPs was 2004 and therefore evidence of improvement was not assessed in the last review, but will be assessed for the 2005 review. The PIP topics were as follows:

- Improving the Use of Appropriate Medications for People with Asthma
- Adolescent Immunization Status, Combination 2

[2]The NCQA *HEDIS Compliance Audit*™ is a trademark of NCQA.

The Anthem's Operational Systems Review assessed activities performed by the MCO during the time frame of January 1, 2005 through December 31, 2005 (CY 2005). The purpose was to identify, validate, quantify, and monitor problem areas in the overall quality improvement program. The review incorporated regulations set forth under the final rule of the BBA that became effective on August 13, 2002. The BBA is the comprehensive revision to federal statutes governing all aspects of Medicaid managed care programs as set forth in Section 1932 of the Social Security Act and Title 42 of the *Code of Federal Regulations* (CFR), part 438 *et seq.* In support of these regulations and health plan contractual requirements, Delmarva evaluated and then assessed compliance for the following systems:

- Enrollee Rights (ER) and Protections—Subpart C Regulation
- Quality Assessment and Performance Improvement (QAPI)—Subpart D Regulation
- Grievance Systems (GS)—Subpart F Regulation

It is expected that each health plan will use the review findings and recommendations for operational systems improvement to become fully compliant with all standards and requirements.

The operational systems standards used in the calendar year (CY) 2005 review were the same as those used in the 2004 review period (January 1, 2004-December 31, 2004) and in the 2003 review period (June- December 2003). These standards incorporate both the BBA and Medallion II contractual requirements. Specifically, these standards include regulations under Subparts C, D, and F of the BBA.

The Operational Systems Review for the period July 2003 through December 2003 was conducted on-site at each MCO. Each element received a compliance rating of "met," "partially met," or "unmet." Only those elements that were not fully met in the 2003 review were assessed as part of the calendar year (CY) 2004 review. The CY 2004 review of Operational Systems consisted of a desk review of all documents provided by the MCO to assess compliance with all elements that were partially met or unmet in the 2003 review. The CY 2005 review included a review of all operational systems standards as in prior reviews and was conducted on-site at the MCO as in the 2003 review.

Quality at a Glance

Ensuring quality of care for Medicaid managed care recipients is a key objective of the Medallion II program. Various indicators exist that serve as direct and proximate measures of the quality of care and services provided to Medallion II recipients. Along with access and timeliness, these indicators are essential components of a quality-driven system of care, which is vital for the success of the Medallion II program. Data obtained from clinical studies performed by Delmarva as well as through other avenues of data support the delivery of quality health care to the Medallion II population. The findings related to quality are reported in the following sections.

HEDIS

Three HEDIS measures served as proxy measures for clinical quality:

- Childhood Immunizations
- Adolescent Immunizations
- Breast Cancer Screening

The HEDIS 2006 results are presented in Table 1 below.

Table 1. Measures of Quality – Childhood Immunization Status, Adolescent Immunization Status, and Breast cancer Screening Rates*

Measure	Anthem	Medallion II Weighted Average CY 2005	HEDIS 2005 National Medicaid Average
Childhood Immunization Status Combination 2	69.8%	68.1%	62.9%
Adolescent Immunization Status Combination 2	33.9%	34.5%	38.4%
Breast Cancer Screening	50.9%	52.6%	54.0%

*Data in this table was submitted by the MCO and not validated by Delmarva.

Anthem exceeded the Medallion II Average and the HEDIS 2005 National average for the Childhood Immunization Status measure. Anthem fell slightly below the Medallion II Average (34.5%) for the Adolescent Immunization Status measure with a rate of 33.9%.The MCO did not exceed the Medallion II Average or the HEDIS 2005 National Medicaid Average for the Adolescent Immunization Status and Breast Cancer Screening measures. While the Childhood Immunization Status Measure is above both averages, there is still room for improvement for all three measures. It is therefore recommended that Anthem continue its participation with the other Medallion MCOs in the collaborative project to improve immunization rates. It is also recommended that Anthem further investigate the need for a project on breast cancer screening or at a minimum conduct a barrier analysis.

Performance Improvement Projects

Anthem appropriately used the quality process of Performance Improvement Projects (PIPs) to identify a problem relevant to their health plan population. The PIP process also required setting a measurement goal, obtaining a baseline measurement, and performing targeted interventions aimed at improving the performance. After the remeasurement periods, qualitative analyses often identified new barriers that affect

success in achieving the targeted goal. Thus, quality improvement is an ever-evolving process focused on improving outcomes and health status.

As in the 2004 review, all MCOs conducted a PIP targeting their population receiving treatment for asthma in 2005. This is an MCO system-wide initiative (enrollee, provider, and administrative) that presents potential barriers to improved enrollee health outcomes. Each MCO chose study indicators and data collection procedures that were based upon HEDIS measures and specifications.

A focus on asthma by each of the MCOs addresses an important opportunity for improvement in the member population based on review of Medicaid HMO plan-specific and national data. Asthma ranked in the top diagnoses for MCO inpatient admissions, emergency department visits, and outpatient office visits.

Anthem implemented a PIP targeted at improvement of its adolescent immunization status. This is an appropriate topic for selection based on the HEDIS results presented in the section above. Since 2004 was considered a baseline year for submission of the second PIP, improvement was not assessed in the last annual review.

Performance on the PIPs are summarized in Table 2 below.

Table 2. PIP Performance Results for Anthem*

PIP Activity	Indicator	Baseline	Remeasurement				
			#1	#2	#3	#4	#5
Anthem		2004	2005				
Improving the Use of Appropriate Medications for People with Asthma	**Quantifiable Measure #1:** Percent of members who had at least one dispensed prescription for inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers, or methylxanthines in the measurement year.	68.5%	95.1%				
		2004	2005				
Adolescent Immunization Combination 2 Rate Analysis	Percentage of enrolled adolescents who turned 13 years of age during the measurement year, were continuously enrolled for 12 months immediately before their 13th birthday, and were identified as having had a second dose of MMR, three Hepatitis B, and one Varicella vaccine by their 13th birthday.	33.2%	33.9%				

*Data in this table was submitted by the MCO and not validated by Delmarva.

An understanding of the quality improvement process, as it relates to PIPs was evidenced by Anthem as documented in its project submission. The asthma indicator increased from 68.5% to 95.1% from 2004 to 2005. Additional interventions were implemented in 2005 which included a member newsletter article and a telephone call to members with asthma to inform them of the need for regular doctor visits, following asthma treatment plans, avoiding triggers, and the importance of compliance with medications.

The immunization indicator improved slightly from the baseline of 33.2% to 33.9% in 2005. Interventions implemented in 2005 included various newsletters and reminders for immunizations.

Operational Systems Review

The standards that pertain to quality and were used to assess the Medallion II MCOs performance in the area of quality are listed below.

Enrollee Rights and Protections—Subpart C Regulations

- ER.1. Enrollee Rights and Protections-Staff/Provider
- ER.6. Advanced Directives

Quality Assessment and Performance Improvement—Subpart D Regulations

- QA3. 438.206 Availability of Services (b) (3)
- QA5. 438.206 (c) (2) Cultural Considerations
- QA6. 438.208 Coordination and Continuity of Care
- QA11. 438.210 (b) Coverage and Authorization of Services—Processing of Requests
- QA15. 438.214 (b) Provider Selection—Credentialing and Recredentialing Requirements
- QA16. 438. 214 (c) Provider Selection—Nondiscrimination
- QA17. 438.12 (a,b) Provider Discrimination Prohibited
- QA18. 438.214 (d) Provider Selection—Excluded Providers
- QA19. 438.56 (b) Provider Enrollment and Disenrollment—Requested by MCO
- QA20. 438.56 (c) Provider Enrollment and Disenrollment—Requested by Enrollee
- QA21. 438.228 Grievance Systems
- QA22. 438.230 Subcontractual Relationships and Delegation
- QA23. 438.236 (a,b) Practice Guidelines
- QA24. 438.236 (c) Dissemination of Practice Guidelines
- QA25. 438.236 (d) Application of Practice Guidelines
- QA26. 438.240 Quality Assessment and Performance Improvement Program
- QA27. 438.240 (b) (2) Basic Elements of Quality Assessment and Performance Improvement (QAPI) Program—Under/Over Utilization of Services
- QA28. 438.240 (b) (3) Basic Elements of QAPI Program—Special Health Care Needs
- QA29. 438.242 Health/Management Information Systems

Grievance Systems—Subpart F Regulations

- GS1. 438.402 (a,b) Grievance System
- GS2. 438.402 (3) Filing Requirements—Procedures
- GS3. 438.404 Notice of Action
- GS4. 438.404 (b) Content of Notice of Action
- GS5. 438.416 Record-Keeping and Reporting Requirements
- GS6. 438.406 Handling of Grievances and Appeals—Special Requirements for Appeals

The following section provides a detailed assessment of the Medallion II MCO's performance in calendar year 2005 as it relates to the operational systems review findings for quality. This year's on-site review included an assessment of all elements and standards, whereas last year, the review focused only on those elements found to be deficient from the previous year.

The Quality Assessment and Improvement program appears to be functioning well with all Quality Assessment and Performance Improvement standards related to quality being met. This is an improvement from the last review. Only one of the Enrollee Rights Standards was not fully met in 2004. It was recommended that Anthem should focus its efforts on developing and implementing a policy stating how enrollees will be informed about the availability of a no-cost second opinion. This was addressed in 2005 and is now fully met in this review.

The Member Handbook and Evidence of Coverage contains language informing members that written materials are available in an alternative format for those with visual and hearing impairments and translated or explained for those with limited English or reading proficiency. There are policies and procedures in place to ensure that members are made aware of the availability of interpreter and translation services free-of-charge to members. The Cultural Needs and Preferences Report identified that the MCO did not meet its goal of 80% of members not having difficulty in finding practitioners who meet their cultural, linguistic, and/or ethnic needs. This report includes actions the MCO plans to take to address these issues.

Procedures are in place to afford members the opportunity to have freedom of choice among network providers, receive a second medical opinion at no cost to the enrollee, and members with special needs can request a specialist as their PCP. Female members have direct access to women's health specialists within MCO network for routine and preventative care services, including obstetrical and gynecological services without a referral.

Comprehensive policies and procedures are in place to ensure coordination of care for members with special needs, including those with behavioral health concerns. Behavioral health coordination is assessed in the report entitled Continuity and Coordination between Medical Care and Behavioral Health Care Analysis for 2004-2005. The Care Management Policy discusses how a care management plan is developed. An

individualized plan of care for the member is developed involving the member or authorized representative, PCP, specialists, or other treating providers after the member agrees to care management. While the elements of the case management plan are appropriate, there is no overall monitoring standard or requirement that would ensure that all steps of creating a case management plan are occurring "in a timely manner" as required by the element. It is recommended that this be included in the next revision of the Care Management Policy.

Anthem has a comprehensive set of policies and procedures for its health plans that address confidentiality and privacy of member information requirements as required by HIPAA. Procedures are in place for Anthem to provide an individual's PHI available to DMAS within 30 days of request as required by contract.

Anthem has a comprehensive provider credentialing and recredentialing process in place. Delegation procedures are in place and require a pre-assessment of any potential delegate and routine performance monitoring of all delegates. There are sanctioning processes in place for providers with substandard performance. A review of provider credentialing and recredentialing files and delegated agreements provided documentation that this process is in place and functioning well.

Clinical practice guidelines including preventive and disease specific guidelines are in place, are distributed to providers and are available to members if requested. Guidelines are approved by the Quality Improvement Committee. Per the Anthem Clinical Practice Guideline Development and Monitoring Policy, Clinical guidelines are used as the basis of the disease management programs. Annually the MCO measures performance against four non-preventive clinical practice guidelines, two of which relate to behavioral health. The measurements utilized for each guideline relate to the clinical process of care.

The Staff Inter-Rater Reliability and Physician Inter-Rater Reliability policies and procedures describe how Anthem ensures, by its assessment requirements, consistent application of utilization review criteria by physician and non-physician utilization staff. Pre-authorization processes include an expedited process to ensure members receive authorizations on a timely basis in those cases where a delay in receiving authorization could negatively impact the health of their members.

In general, complaint, grievance and appeals policies and procedures are in place. Anthem prohibits individuals from providing incentives for denying, limiting, and/or discontinuing medical services. Consistent with this process, the MCO provides written notice of adverse decisions. The notifications to the members and providers include all the required components including the member right to a State Fair Hearing. Only one Grievance System standard related to quality was not met and this can be easily remedied by adding information to standard notices of action. Specifically, Anthem must ensure that the notices of action contain a description of the right to request that benefits continue pending appeal resolution and the circumstances under which the enrollee may be required to pay the costs of services.

Summary of Quality

Three HEDIS measures were used as proxy measures for quality; Childhood Immunization Status, Adolescent Immunization Status, and Breast Cancer Screening rates. Although Anthem exceeded the Medallion II Average and the HEDIS 2005 National averages for the Childhood Immunization Status measure, the remaining two measures fell below these averages. While the Childhood Immunization Status Measure is above both averages, there is still room for improvement for all three measures. It is therefore significant that Anthem developed a PIP targeting improvement in the adolescent immunization rate. If not already in progress, Anthem may want to consider implementing quality improvement projects to address the childhood immunization status and breast cancer screening rates.

The required PIPs have been developed and implemented according to timetables specified by DMAS. The project topics of asthma and adolescent immunization status are relevant and appropriate for the MCO's population. Anthem achieved an increase in the performance indicators for both projects. Interventions implemented in 2005 for the immunization project included newsletter articles and one mailing to request immunization records for children and adolescents. The major asthma PIP interventions included mailings with telephone calls to members to inform them of the need for regular doctor visits, treatment plans, avoiding asthma triggers, and compliance with medication.

Anthem met the requirements for all of the Quality Assessment and Performance Improvement standards related to quality in the CY 2005 review which is an improvement over the last review. The appropriate policies and procedures are in place and have been implemented to address concerns identified in the last review, demonstrating the MCO's commitment to quality.

Access at a Glance

Access is an essential component of a quality-driven system of care, and historically has been a challenge for Medicaid recipients enrolled in fee-for-service programs. The intent of the Medallion II program is to improve access to care. One of DMAS's major goals in securing approval of the 1915(b) Medicaid waiver application was to develop managed care delivery systems that would remove existing barriers for Medicaid recipients, thereby improving their overall health status, increasing their quality of life, and reducing costly health expenditures related to a fragmented system of care. The findings with regard to access are described below.

HEDIS

The HEDIS performance measures are used to evaluate access and availability of care through the Prenatal and Postpartum Care results as compared with both the Medallion II and the NCQA Medicaid averages. Two rates are calculated for this measure:

- Timeliness of Prenatal Care[3]
- Postpartum Check-up Following Delivery[4]

Table 3 provides the HEDIS results for the Medallion II MCOs for these two measures pertaining to access.

Table 3. Access Measures - Prenatal and Post Partum Care*

Measure	Anthem	Medallion II Weighted Average CY 2005	HEDIS 2005 National Medicaid Average
Timeliness of Prenatal Care	88.5%	84.1%	78.3%
Postpartum Care	64.2%	59.9%	55.9%

***Data in this table was submitted by the MCO and not validated by Delmarva.**

Anthem's rates for both HEDIS access measures exceeded both the Medallion II and HEDIS 2005 National Medical Average. The Medallion II Average is also above the NCQA Medicaid HEDIS 2005 Average.

Performance Improvement Projects

The PIPs implemented by the Medallion II MCOs focused on improvement of clinical indicators. However, within the barrier analyses for each project, potential access barriers also were examined. The following section provides an MCO level specific summary of access issues identified by the Medallion II MCOs through implementation of the PIPs related to asthma.

The identification of access barriers was found in Anthem's PIP aimed at improving the use of appropriate medications for people with asthma. In the 2004 review it was noted that Anthem had identified barriers related to the member, caregiver, and physician lack of awareness about the Asthma Disease Management Program, which affected member access to the program. In 2005 additional barriers were noted. These included a lack of knowledge of the management of asthma, inability to identify asthma triggers, and the lack of self-management/caregiver action including the long term control of asthma. Interventions implemented in 2005 to address these issues included member newsletter articles and telephone calls to asthmatic members to inform them of the need for regular doctor visits, to follow their treatment plans, to avoiding triggers and comply with asthma medications.

[3] Timeliness of Prenatal Care measures the percentage of women in the denominator who received a prenatal care visit in the first trimester or within 42 days of enrollment.
[4] Postpartum Check-up Following Delivery measures the percentage of women in the denominator who had a postpartum visit on or between 21 days and 56 days following delivery.

Operational Systems Review

In 2004, as part of a desk-review, Delmarva comprehensively reassessed elements from the previous year's review that previously were not fully met and found that the majority of all elements had improved to a met status. In 2005, Delmarva reassessed all elements and standards as part of the Operational Systems Review. Delmarva's Operational Systems Review of the Medallion II MCOs evaluated elements pertaining to access in the following required review categories. These elements pertain to this and last year's review to provide a complete evaluation of the Medallion II MCOs performance in the area of access. The following standards were used to assess the MCOs compliance with access standards.

Enrollee Rights and Protections—Subpart C Regulations

- ER3. Information and Language Requirements (438.10)
- ER5. Emergency and Post-Stabilization Services (438.114, 422.113c)
- ER7. Rehabilitation Act, ADA

Quality Assessment and Performance Improvement—Subpart D Regulations

- QA1. 438.206 Availability of Services (b)
- QA2. 438.206 Availability of Services (b) (2)
- QA4. 438.206 Availability of Services (b) (4)
- QA7. 438.208 (c) 103 Additional Services for Enrollees with Special Health Care Needs
- QA8. 438.208 (c) (4) Direct Access to Specialists
- QA10. 438.208 (e) Primary Care and Coordination Program

Anthem performed well in the area of information and language requirements, emergency and post-stabilization services, and the Rehabilitation Act requirements. Anthem also performed well in the areas of availability of services, access to specialists, and primary care coordination.

The Anthem Member Handbook and Evidence of Coverage provide members with information about all services available to them and how to access these services. Anthem has performed successfully in this review regarding services for enrollees with special health care needs. Anthem makes a good faith effort to conduct an assessment of enrollees with complex, serious, and/or disabling conditions as identified and reported by the state, within 90 days receipt of notification of Social Security Insurance (SSI) children. An additional area of strength for Anthem is the primary care and coordination program. Anthem coordinates services furnished to enrollees with those of other MCOs to prevent duplication.

Anthem has the appropriate access standards in place and these are distributed through the Provider Manual and newsletters. The Availability Report provides an analysis of access data compared to Anthem's standards and is completed annually. The Managed Care Accessibility Analysis addresses member access to network hospitals and other member services.

As noted in the Quality section, Anthem affords members the opportunity to have freedom of choice among network providers, receive a second medical opinion at no cost to the enrollee, and request of a specialist as their PCP by members with special needs. Female members have direct access to women's health specialists within MCO network for routine and preventative care services, including obstetrical and gynecological services without a referral. There are also procedures in place to ensure that members have access to out-of-network services when Anthem is unable to provide needed services within its network.

Anthem has pre-authorization procedures in place within a functioning process. Timeliness of completion of pre-authorization activities is monitored through the appropriate channels. There are expedited procedures in place to ensure that enrollees receive timely decisions in cases where extenuating circumstances exist. Individuals with the appropriate credentials make the authorization decisions. There are no incentives for persons making the determinations to deny, reduce or limit services. Turn-around timeframes outlined in policies are in accordance with contractual requirements and allow extensions when requested by enrollees.

Summary of Access

Overall, access is an area of strength for Anthem and supports the health plan's intent as a quality-driven system of care. Anthem's performance on the HEDIS prenatal measures related to access exceeded both the Medallion II and HEDIS 2005 National Medicaid averages. Anthem developed and implemented PIPs related to asthma and adolescent immunizations which are relevant to its population. Anthem met all of the requirements of the Operational Systems Review related to access. Combining all the data sources used to evaluate access Anthem addressed the areas where the health plan showed vulnerability and corrected identified access issues, furthering the plan in its goal to implement a managed care delivery system that addresses existing barriers for Medicaid recipients.

Timeliness at a Glance

Access to necessary health care and related services alone is insufficient in advancing the health status of Medallion II recipients. Equally important is the timely delivery of those services, which is an additional goal, established by DMAS for the systems of care that serve Medallion II recipients. The findings related to timeliness are revealed in the sections that follow.

HEDIS

Timeliness of care was investigated in the results of the following HEDIS measures, which the Medallion II MCOs (except AMERIGROUP) were required to submit:

- Well-Child Visits in the First 15 Months of Life[5]

[5] Well-Child Visits in the First 15 Months of Life measures the percentage of enrolled members who turned 15 months old during the measurement year, who were continuously enrolled in the Plan from 31 days of age, and who received six or more well child visits with a primary care practitioner during their first 15 months of life.

- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life[6]
- Adolescent Well-Care Visits[7]

Table 4 provides the HEDIS measure results for the Medallion II MCOs pertaining to timeliness.

Table 4. Timeliness Measures- Well Child Visits and Adolescent Well Care*

Measure	Anthem	Medallion II Weighted Average CY 2005	HEDIS 2005 National Medicaid Average
Well Child Visits in the First 15 Months of Life (6 or more visits)	41.9%	47.3%	46.8%
Well Child Visit in the 3rd, 4th, 5th, and 6th Year of Life	59.8%	59.7%	61.9%
Adolescent Well Care	27.2%	29.6%	40.3%

*** The data in this table was submitted by the MCO and was not validated by Delmarva.**

The rate for the Well Child Visits in the First 15 Months of Life measure for Anthem was below both the Medallion II Average and the HEDIS 2005 National Medicaid Average. The Medallion II average for this measure was 47.3%, which exceeds the NCQA Medicaid HEDIS 2005 average of 46.8%.

Anthem's rate for the Well Child Visit in the 3rd, 4th, 5th, and 6th Year of Life measure was 59.8% which is slightly above the Medallion II Average (59.7%), but below the Medicaid HEDIS 2005 National Average.

The Adolescent Well Care measure was 27.2% for Anthem. This is below the Medallion II Average and the HEDIS 2005 National Medicaid Average.

Two of the three HEDIS measures that assessed timeliness were below the Medallion II Average, and all three were below the HEDIS 2005 National Medicaid Average. This represents an opportunity for improvement for Anthem.

[6] Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life measures the percentage of members who were three, four, five or, six years old during the measurement year, who were continuously enrolled during the measurement year, and who received one or more well-child visit(s) with a primary care practitioner during the measurement year.
[7] Adolescent Well-Care Visits measures the percentage of enrolled members who were age 12 through 21years during the measurement year who were continuously enrolled during the measurement year and who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.

Performance Improvement Projects

In 2004, timeliness was a focal area of attention in the Medallion II MCO PIPs. In 2004, Anthem's interventions included publishing member newsletter articles and the completion of telephone calls via the Televox, an automated telephone system, to members identified with asthma. Information provided via Televox included information about the need for regular doctor visits, following treatment plans, avoiding triggers, and compliance with asthma medication.

The barriers used to develop interventions for the asthma project in 2005 were the same as those in 2004 and include lack of (1) knowledge or self/caregiver in asthma management, (2) the ability to identify asthma triggers, and (3) asthma self-management/caregiver action plans that include long term control of asthma. Interventions in 2005 included publishing additional newsletter articles and conducting telephone calls using Televox as in 2004. Interventions for the immunization project included member newsletter articles and a request for immunization records.

Issues related to timeliness of services may very likely be affected by access. The Medallion II MCO PIP, aimed at improving an important asthma performance measure, uses HEDIS methodology and target services received (access) as well as on the time frame in which the services were provided (timeliness).

Operational Systems Review

Access to necessary health care and related services alone is insufficient in advancing the health status of Medallion II recipients. Equally important is the timely delivery of those services, which is an additional goal, established by DMAS for the systems of care that serve Medallion II recipients. The findings related to timeliness are revealed in the sections to follow. Delmarva assessed the Enrollee Rights, Quality Assessment and Performance Improvement, and Grievance System standards to evaluate Anthem's commitment to timeliness of services.

Delmarva's operational systems review of the Medallion II MCOs assessed and documented elements pertaining to timeliness in the following review requirement categories. These elements pertain to the 2005 and last year's review to provide a complete evaluation of the Medallion II MCOs performance in the area of timeliness. Standards used to assess the Medallion II MCOs compliance with timeliness are included below.

Enrollee Rights and Protections—Subpart C Regulations

- ER2. Written Statement Upon Enrollment
- ER4. 42 C.F.R. 431, Subpart F, and the Code of Virginia, Title 2.1, Chapter 26, (Privacy and Protection Act of 1976) and the Health Insurance Portability and Accountability Act of 1996

Quality Assessment and Performance Improvement—Subpart D Regulations

- QA9. 438.208 (d) (2) (ii-iii) Referrals and Treatment Plans

- QA11. 438.210 (b) Coverage and Authorization of Services—Processing of Requests
- QA12. 438.210 (c) Coverage and Authorization of Services—Notice of Adverse Action
- QA13. 438.210 (d) (1) Timeframe for Decisions—Standard Authorization of Decisions
- QA14. 438.210 (d) (2) Timeframe for Decisions—Expedited Authorization Decisions

Grievance Systems—Subpart F Regulations

- GS7. 438.408 Resolution and Notification: Grievances and Appeals—Standard Resolution
- GS8. 438.408 Resolution and Notification: Grievances and Appeals—Expedited Resolution
- GS9. 438.408 (b-d) Resolution and Notification
- GS10. 438.408 (c) Requirements for State Fair Hearings
- GS11. 438.410 Expedited Resolution of Appeals, GS. 438.424 Effectuation of Reversed Appeal Resolutions

In the last review a recommendation pertaining to the expedited authorization decision timeframe element was made. Anthem was advised to add language to existing written policies and procedures that would describe the extension time frames for expedited authorizations allowed under the state contract. This was completed, and therefore this is met in 2005.

Anthem performed well in the areas of timeliness to include privacy protection and the Health Insurance Portability and Accountability Act (HIPAA), resolution and notification: grievances and appeals, and requirements for state fair hearings. Anthem has an expedited appeal process with a process for extension, and for notifying enrollees of reason for delay. The notices of action include all required information and are provided to members and providers according to required timeframes. Members are informed of their rights to file an external appeal to DMAS within 30 days of the receipt of an adverse determination notice.

Expedited appeals and authorization processes are in place to ensure that members with extenuating circumstances are provided notice as expeditiously as the enrollee's health condition requires and no later than three (3) working days after receipt of the request for service. There are also procedures in place to allow members to request extensions where such an extension would be in their best interest.

Only one Quality Assessment and Performance Improvement standard was not fully met and relates to timeliness. The Care Management Policy discusses the development of a care management plan. An individualized plan of care for the member is developed involving the member or authorized representative, PCP, specialists, or other treating providers, after the member agrees to care management. While the elements of the case management plan are appropriate, there is no overall monitoring standard or requirement that would ensure that all steps of creating a case management plan are occurring "in a timely manner" as required by the element. It is recommended that a methodology for capturing time frames and ensuring compliance with the established time frames be implemented.

Summary of Timeliness

In regards to timeliness, only the Well Child Visits in the 3rd, 4th, 5th, and 6th Year of Life measure exceeded the Medallion II Average while none of the measures exceeded the HEDIS Medicaid National Average. Access to well-child visits and adolescent well care therefore represent an opportunity for improvement efforts.

In 2004, timeliness was an area of attention in regards to PIPs. This continued in 2005, when many of the same barriers were encountered. Interventions remained consistent from 2004 with newsletter articles and contacting members via the Audiovox system.

The Operational Systems Review included standards from the BBA regarding Enrollee Rights (ER) and Quality Assessment and Performance Improvement (QAPI). Anthem met all requirements for all standards related to ER and QAPI for 2005.

Overall Strengths

Quality:

- The MCO exceeded the Medallion II average and the HEDIS 2005 Medicaid National Average for the Childhood Immunization Status measure.
- Anthem demonstrated through its documentation a clear understanding of the PIP process in regards to the identification of project topics, development of indicators, barrier analysis.
- All Quality Assessment and Performance Improvement standards used to assess quality were met.
- The credentialing policies and procedures are in place and functioning well based on a review of provider credentialing and recredentialing files.
- The Continuity and Coordination between Medical Care and Behavioral Health Care Analysis for 2004-2005 provides information for Anthem to use in its quality improvement efforts.
- Anthem has a comprehensive set of policies and procedures for its health plans that address confidentiality and privacy of member information requirements as required by HIPAA and the DMAS contract.
- Inter-rater reliability procedures are in place to ensure the consistent application of utilization management criteria.

Access:

- The two HEDIS measures used as proxies for access, Timeliness of Prenatal Care and Postpartum Care exceeded the HEDIS 2005 Medicaid National Average. The Timeliness of Prenatal Care measure also exceeded the Medallion II average.

- Anthem makes a good faith effort to conduct an assessment of enrollees with complex, serious, and/or disabling conditions as identified and reported by the state, within 90 days receipt of notification of Social Security Insurance (SSI) children. An additional area of strength for Anthem is the primary care and coordination program. Anthem coordinates services furnished to enrollees with those of other MCOs to prevent duplication.
- Anthem has documented the appropriate access standards which are assessed on at least an annual basis. Their findings are documented in a report with recommendations for improvements where deficiencies are identified.
- The pre-authorization procedures are in place with no incentives for staff to deny, reduce or limit services.

Timeliness:

- One of the HEDIS measures used as a proxy for timeliness, Well Child Visits in the First 15 Months of life (6 or more visits), exceeded the Medallion II average.
- Anthem has pre-authorization procedures in place and functioning within their processes. The timeliness completion of pre-authorization activities is monitored through the appropriate channels.
- There are expedited authorization procedures in place to ensure that enrollees receive timely decisions in cases where extenuating circumstances exist.
- Turn-around timeframes for authorization of services are outlined in policies, are in accordance with contractual requirements, and allow extensions when requested by enrollees. Timeliness of these decisions is also monitored through the quality improvement channels.
- Anthem performed well in the areas of timeliness to include privacy protection and HIPAA requirements.
- Anthem has an expedited appeal procedure with a process for extension and for notification of enrollees with reasons for any delays. The notices of action include all required information and are provided to members and providers according to required timeframes. Members are informed of their rights to file an external appeal to DMAS within 30 days of the receipt of an adverse determination notice.

Recommendations

This section offers DMAS a set of recommendations to build upon identified strengths and to address the areas of opportunity within the existing programs. These recommendations draw from the findings of those data sources individually and in the aggregate. Delmarva's recommendations for Anthem are as follows:

HEDIS measures can provide an MCO with valid and reliable data for planning purposes. The HEDIS measures used as proxies for quality included Childhood Immunization Status (Combination 2), Adolescent Immunization Status (Combination 2), and Breast Cancer Screening. Of these three measures, only the

Childhood Immunization Status measure exceeded the Medallion II and HEDIS 2005 Medicaid National Average. Although the Childhood Immunization Status Measure is above both averages, there is still room for improvement for all three measures. It is therefore recommended that Anthem continue its participation with the other Medallion MCOs in the collaborative project to improve immunization rates. It is also recommended that Anthem further investigate the need for a project on breast cancer screening or at a minimum conduct a barrier analysis.

All three HEDIS measures used as proxies for timeliness were below the Medallion II and HEDIS 2005 Medicaid National Average, except for the Well Child Visit in the 3rd, 4th, 5th, and 6th Year of Life measure which exceeded the Medallion II rate by .1 of a percentage point. It is clear that Anthem should review these access measures and determine the need for a quality improvement project related to well child and adolescent well care visits.

PIPs provided for review include asthma and a newly implemented project to improve the status of adolescent immunizations. Because the 2005 data was calculated by the MCO recently, it is necessary Anthem to conduct another barrier analysis and an assessment of the effectiveness of its prior interventions. After this review and analysis, it is important for the MCO to modify or implement additional interventions to address identified barriers. Anthem should consider more robust interventions that include educational targeting of physicians.

Only one Quality Assessment and Performance Improvement standard was not fully met and it relates to timeliness. The Care Management Policy discusses how a care management plan is developed. After the member agrees to care management, an individualized plan of care is developed involving the member or authorized representative, PCP, specialists, or other treating providers. While the elements of the case management plan are appropriate, there is no overall monitoring standard or requirement to ensure that all steps of creating a case management plan are occurring "in a timely manner" as required by the element. It is recommended that a methodology for capturing time frames and ensuring compliance with the established time frames should be implemented.

The notices of action reviewed by Delmarva did not contain a description of the right to request that benefits continue pending appeal resolution and the circumstances under which the enrollee may be required to pay the costs of services. Several of the files reviewed did indicate that concurrent review decisions could result in the member's being "held harmless' for the charges incurred, and that the treating provider would have to file an appeal to the determination. It is recommended that Anthem put processes in place and revise notices of action documents to ensure that the notices of action contain a description of the right to request that benefits continue pending appeal resolution and the circumstances under which the enrollee may be required to pay the costs of services.

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Centers for Medicare and Medicaid Services (CMS). (2002, June). *Final Rule: Medicaid Managed Care; 42 CFR Part 400, et.al., Subpart D- Quality Assessment and Performance Improvement.* Retrieved December 9, 2004, from CMS website: http://www.cms.hhs.gov/medicaid/managedcare/f4289.pdf

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